State: Arizona

Demonstration Name: Arizona Health Care Cost Containment System

Description & Status:

The Demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State plan groups as well as Demonstration expansion groups. The goal of the Demonstration is to provide organized and coordinated health care for both acute and long term care that includes pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. Beneficiaries receiving long term care services receive additional benefits that would not otherwise be provided through the Medicaid State plan. In addition, the Demonstration enables the State to operate a coverage expansion program for children with income up to 175 percent of the Federal poverty level, as well as the authority to create a Safety Net Care Pool to help offset uncompensated care costs incurred at participating hospitals. Finally, the Demonstration enables to the State to make uncompensated care payments to Indian Health Service and tribal health facilities.

Populations:

All populations that derive their eligibility from the Arizona Medicaid State plan, including the elderly and the disabled who receive long term care services, participate in the Demonstration. Adults without children with family income up to 100 percent of the Federal poverty level (FPL) are eligible to participate in the Demonstration as they are an expansion population. The only population that is not mandatorily enrolled into the Demonstration is the American Indian/Alaskan Native population who can elect to remain in Arizona's fee-for-service program, or can elect to participate in the Demonstration to receive their benefits through a managed care delivery system. Children with family income up to 175 percent of the FPL are eligible for the KidsCare II program, which derives its authority to operate under the Demonstration.

Approval Date: October 21, 2011

Effective Date: October 22, 2011

Expiration Date: September 30, 2016

Pending Actions:

There are two amendments currently in house:

1. Creation of a statewide medical homes project for the American Indian/Alaskan Native population; and
2. Integration of behavioral and physical health for children enrolled in the Children's Rehabilitative Services program and for individuals with serious mental illness.

ARIZONA DEMONSTRATION
FACT SHEET

April 24, 2012

Name of Section Demonstration/Waiver: Arizona Health Care Cost Containment System (AHCCCS) 1115 Demonstration

Date Proposal Submitted: March 31, 2011
Date Proposal Approved: October 21, 2011
Date Implemented: October 22, 2011
Date Expires: September 30, 2016

Number of Amendments: **2**

SUMMARY

Until 1982, Arizona was the only State that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the State's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the State's capitated long term care (LTC) program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the State also expanded coverage to adults without dependent children with family income up to and including 100 percent of the Federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to terminate its initial section 1115 demonstration in order to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the State's required phase-out plans for the MED program and the adults without dependent children population, respectively.

The new Demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid State plan groups as well as Demonstration expansion groups. The goal of the Demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The Demonstration affects coverage for certain specified mandatory State plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the Demonstration will test the use of managed care entities to provide cost effective care coordination. The Demonstration also provides coverage to limited groups the State does not currently cover under its Medicaid State plan, including adults without

dependent children, and a limited number of children with incomes above the levels under the Medicaid State plan and at or below 175 percent of the FPL, which will show the benefits of such coverage using these approaches to a wider population. In addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

AMENDMENTS

Number of Amendments: 2

Amendment #1:	Provides the State with the authority to: establish the KidsCare II program which provides coverage to children with family income up to 175 percent of the FPL; establish the Safety Net Care Pool; and make uncompensated care payments to Indian Health Services' facilities as well as to "638" facilities.
Date Amendment #1 Submitted:	Outstanding Items from the State's March 31, 2011 section 1115 demonstration application
Date Amendment #1 Approved:	April 6, 2012
Date Amendment #1 Effective:	April 6, 2012
Amendment #2:	Provides authority for the State create a Statewide medical home project for the AI/AN population to promote care coordination for the FFS AI/AN beneficiaries and integrate behavior and physical health for the SMI population and children enrolled in the State's Children's Rehabilitative Services program.
Date Amendment #2 Submitted:	August 11, 2011 February 7, 2012 April 18, 2012
Date Amendment #2 Approved:	Under CMS review
Date Amendment #2 Effective:	Under CMS review

ELIGIBILITY/ENROLLMENT

All populations that derive their eligibility from the Arizona Medicaid State plan, including the elderly and the disabled who receive long term care services, participate in the Demonstration. Adults without children with family income up to 100 percent of the Federal poverty level (FPL) are eligible to participate in the Demonstration as they are an expansion population. The only population that is not mandatorily enrolled into the

Demonstration is the American Indian/Alaskan Native population who can elect to remain in Arizona's fee-for-service program, or can elect to participate in the Demonstration to receive their benefits through a managed care delivery system.

State Reported Enrollment in the Demonstration (as requested)	Current Enrollees
Title XIX funded State Plan[1]	1,131,016
Title XXI funded State Plan[2]	12,839
Title XIX funded Expansion[3]	153,512
Title XXI funded Expansion[4]	0
Family Planning Only	4,473
Enrollment Current as of	1/1/12

DELIVERY SYSTEM

Acute care services are provided by ten private or county-owned health plans, which are selected through a competitive bidding process. To help ensure that AHCCCS beneficiaries have access to appropriate medical care, health plan contracts stipulate specific provider networks, ensuring provider availability in both urban and rural locations. All members have a choice of at least two health plans. The acute care health plans also serve the KidsCare population.

The ALTCS program is managed by AHCCCS through nine program contractors who are responsible for the EPD delivery system. Program contractors are responsible for providing all acute care services covered under AHCCCS to LTC eligibles and they are paid a capitation rate for each enrollee. The Arizona Department of Economic Security is the sole program contractor for the DD population statewide.

There are two separate delivery systems for behavioral health services in Arizona: one for persons enrolled in the acute care program and one for persons enrolled in the long term care program. All behavioral health services for enrollees in the acute care program are administered through the Arizona Department of Health Services, which in turn subcontracts with five Regional Behavioral Health Authorities (RBHAs) and three tribal RBHAs (TRBHAs) located throughout the State. The RBHAs are responsible for client evaluation and diagnosis, service and treatment planning, case management, coordination with the Health Plan, and providing all behavioral health services through subcontracts with behavioral health providers. For ALTCS enrollees, services are administered through the Program Contractors. The Program Contractors may contract for behavioral health services through providers or the RBHAs.

[1] SSI, 1931 Families and Children, 1931 Related, TMA, SOBRA child and pregnant, ALTCS, FTW, QMB, BCCP, SLMB, QI-1
[2] KidsCare
[3] MI/MN
[4] AHCCCS for Parents

BENEFITS

The AHCCCS program covers inpatient and outpatient hospital services, emergency room care, physician services, outpatient health services, lab, X-ray, pharmacy, behavioral health services, and several other services.

Additional benefits covered under ALTCS include acute care services as well as Nursing Facility days, Intermediate Care Facility for the Mentally Retarded days, case management, behavioral health services, and HCBS. HCBS covered by ALTCS include home health care, homemaker services, personal care, adult day health, hospice, respite care, transportation, attendant care, environmental modification, life line alert, and home-delivered meals. Habilitation and day-care services are also covered for the DD population.

The behavioral health services provided are primarily outpatient. They include individual and group therapy and counseling, emergency crisis behavioral health care, partial care, psychotropic medications, behavior management, and psychosocial rehabilitation. Inpatient psychiatric hospital services are available for persons under 21 years of age. For adults 21 through 64, behavioral health services are covered in three types of inpatient facilities: psychiatric health facilities, detoxification facilities, and crisis stabilization facilities.

Family planning services are provided to eligible recipients who lose SOBRA eligibility at 60 days postpartum for up to 24 months with a re-determination of eligibility, including income, at 12 months. The income limit for re-determination of eligibility is 133 percent of the FPL.

QUALITY AND EVALUATION PLAN

AHCCCS specifies standards that plans must meet for the number and types of providers in each contract's geographical location, requires plans to routinely provide data documenting a plan's stability and levels of care provided, and requires plans to conduct various studies measuring patient outcomes.

Recognizing that most of the Federal requirements for quality assurance activities currently in place are geared to address problems in traditional fee-for-service programs, AHCCCS developed and implemented a Quality Management program tailored for a managed care environment. In 1995, CMS and AHCCCS entered into a partnership on a Quality Management Initiative that is designed to measure health care outcomes with quality indicators and encounter data. AHCCCS regularly submits acute and LTC utilization reports and Quality Indicator reports and also conducts and publishes member satisfaction and provider satisfaction surveys.

COST SHARING

In accord with waivers granted to the State of Arizona, copayments may be imposed on covered services. Providers are responsible for the collection of copayments from members. The following is a listing of Cost Sharing by program:

Arizona Acute Care Program (AACP) Cost Sharing – Cost sharing shall be imposed as specified in the Medicaid State plan for all populations, except for the adults without dependent children with income up to 100 percent of the FPL which are as follows:

Adults without Dependent Children Copayments

Service	Copayment Amount	Geographic Applicability
Generic prescription, or brand name prescription if generic is not available	$4	Statewide
Brand name prescription when generic is available	$10	Statewide
Non-emergency use of the emergency room	$30	Statewide
Physician office visit	$5	Statewide
Non-emergency medical transportation (NEMT) (taxi rides only)	$2 per trip ($4 roundtrip maximum)	Only in Maricopa and Pima counties

The NEMT copayment shall be imposed only on taxi rides for adults without dependent children who reside in Maricopa and Pima counties. Adults without dependent children residing in all other counties within the State are exempt from the NEMT copayment. The American Indian/Alaskan Native (AI/AN) population is also exempt.

In addition, the State may permit a provider to impose a $3 fee on the TANF parent and adults without dependent children population for the non-covered activity of reserving an appointment that an individual misses. This fee can only be imposed on beneficiaries residing outside of Maricopa and Pima counties. The authority for the imposition of this fee is time-limited, and will expire on January 1, 2013. On November 1, 2012, as specified in Special Terms and Conditions, the State must submit an independent evaluation for CMS review and approval documenting the effectiveness of the missed appointment copayment in reducing the number of missed appointments. Upon concluding the review of the evaluation and at the request of the State, CMS may extend this authority to December 31, 2013.

Arizona Long Term Care System (ALTCS) Cost Sharing.

a. Monthly Premiums for ALTCS. The AHCCCS may implement a monthly premium on ALTCS eligible households with an adjusted gross income at or above 400 percent of the FPL that have children under the age of 18 years with developmental disabilities enrolled in ALTCS.
b. The total of all monthly premiums will be 2 percent of the annual adjusted gross income for households with income between 400 percent and 500 percent of the FPL and 4 percent for households with income at and above

500 percent the FPL. There will be no distinction between institutional or non-institutional placements.

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